

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Jasper
 Township Joplin
 City Joplin (No. 2215)

Registration District No. 411
 Primary Registration District No. 2002

File No. 20882
 Registered No. _____
 St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. 2215 Joplin St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W.R. Zachary
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 14 1907
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 10 9

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wagoner Okla

13. NAME C.C. May

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

15. MAIDEN NAME Carey

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT (ADDRESS) Mr W.R. Zachary

18. BURIAL, CREMATION, OR REMOVAL PLACE Wagoner Okla DATE June 24 1934

19. UNDERTAKER (ADDRESS) Sankey, Maryann

20. FILED 6-24-34 Eod to James Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23 1934

22. I HEREBY CERTIFY That I attended deceased from June 16th 1934 to June 23rd 1934
 I last saw her alive on June 23rd 1934. Death is said to have occurred on the date stated above, at 4 P. m.
 The principal cause of death and related causes of importance were as follows:

Acute Nephritis Date of onset 6-16-34
Intestinal Obstruction 6-20-34

Name of operation _____ Date of 6-22-34
 What test confirmed diagnosis? Lab Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) Walter M. Howard M. D.
 (Address) Carthage, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

AUG 16 1934

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WASHINGTON

20882

Jasper

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Virginia May Zachary
 Who died at _____ on June 23-1934
 Residence: No. _____ St. _____
 (If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
 Sex F Color or race W Single, married, widowed or divorced: _____
 Date of birth _____ Age: Years 26 Months 10 Days 9

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Acute nephritis
 Date deceased last worked at this occupation: Month _____ Year _____
 Birthplace (State or country) _____
 Birthplace of father (State or country) _____
 Birthplace of mother (State or country) _____
 Principal cause of death: _____

Intestinal obstruction - adhesions
 Other contributory causes of importance _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Laboratory Was there an autopsy? _____
 If death was due to external causes (violence) fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____
 (Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____
 Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 Name of physician Walter M. Hayward
 Address of physician Carthage Mo.

X Signature of Registrar Ed. J. [unclear] Date filed _____
 This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 411Primary Reg. Dist. No. 2002

E. T. McGaugh
 State Registrar
 Special Agent.

S-20882